REGINALD C. JAMES
SUPERINTENDENT OF SCHOOLS

ERIC F. HINSON
DISTRICT NO. 1
HAVANA, FL 32333

JUDGE B. HELMS, JR.
DISTRICT NO. 2
QUINCY, FL 32351

ISAAC SIMMONS, JR.
DISTRICT NO. 3
CHATTAHOOCHEE, FL 32324
GREENSBORO, FL 32330

CHARLIE D. FROST
DISTRICT NO. 4
GRETNA, FL 32332
QUINCY, FL 32352

ROGER P. MILTON
DISTRICT NO. 5
QUINCY, FL 32353
INTRODUCTION

The purpose of this booklet is to provide a brief description of benefits available to you through The Gadsden County School Board. Should you have any questions concerning the benefits described in this booklet, refer to insurance certificates, policies, or other benefit brochures provided to you. Further questions concerning benefits contained in this booklet should be referred to Insurance and Payroll Benefits at 627-9651 ext 1227.

If there is a conflict between the official plan documents and any statement made in this booklet, the plan documents will control policy and procedures.

Although Gadsden County Schools currently intends to continue all of the benefits described in this booklet, The Board reserves the right to amend, reduce, or terminate any of these benefits at any time.

Neither this booklet nor the official plan documents confer any contractual right to any person to either become or remain an employee of the Gadsden County School District.

The Benefits Plan allows you to pay for benefits, which you choose, on a pretax basis. These benefits are deducted from your gross salary before taxes are calculated. The benefits eligible under the flex plan are:

• Health Insurance - Capital Health Plan, Blue Cross and Blue Shield of Florida
• Dependent Health Care – covered under the individual health plan
• Dependent Dental Insurance – Florida Combined Life Insurance Company
• Medical Flex Spending - Aflac
• Aflac (Cancer, Intensive Care, Critical Care & Recovery, Hospital Indemnity, Accident, Disability, Vision)
• 403B annuities

With pretax, your taxable earnings are reduced, you are taxed less, and you take home more money!

ALL BENEFITS ARE LOCKED IN FOR ONE YEAR UNLESS YOU EXPERIENCE A QUALIFYING EVENT. (See frequently asked questions.)
FREQUENTLY ASKED QUESTIONS

Q. As a new employee, when do I enroll in The Gadsden County School Board benefits program?

A. New employees must be given an opportunity to enroll in the program within the first 30 calendar days of employment. Failure to enroll within that time frame will result in the loss of benefits’ coverage until the next open enrollment period.

Q. What is Open Enrollment?

A. Open enrollment is a period of time when employees are given the opportunity to make changes to benefits which have been elected the prior plan year. During the annual open enrollment period, all current eligible participants may make changes to any of the pre-tax or post-tax benefits. The only other time a change can be made is when there has been a “qualifying status change.” For new employees, the open enrollment period is their first 30 calendar days of employment.

Q. What Happens if I miss the Open Enrollment Period?

A. For those current employees already enrolled, the elections you made the prior year will continue and you must wait until the next year’s open enrollment period to make any changes (unless you experience a “qualifying event”). For new employees, you must wait until the next open enrollment period.

Q. What is a Section 125 Flexible Benefit Plan?

A. It is a benefit plan, sometimes called a cafeteria plan, which allows you to choose tax-free benefits from a "menu" of items. The premiums for the benefits you choose are paid through a salary reduction agreement. Salary reduction means that you are able to pay for benefits with "pre-tax" dollars. This means that you do not pay FICA or withholding taxes on the dollars used to "purchase" benefits.

Q. Who is eligible for benefits under the FlexPlan?

A. Employees working at least 20 hours per week in a regularly established position are eligible for all benefits listed above.

Q. What benefits are available under the FlexPlan?

A. You may choose from the benefits listed below which best fit the needs of you and your family.

The following items are automatically pre-taxed.

- Employee portion of Health Insurance
• Dependent Medical Insurance
• Dependent Dental Insurance
• Aflac
• Medical Flex Expense
• 403B Annuities

Q. Are employees automatically covered under the FlexPlan?
A. No. An employee must enroll in the FlexPlan to participate. All eligible employees must sign an enrollment form.

Q. After enrolling, when will benefits be effective?
A. In most cases, benefits are effective the first of the month you pay the first payroll deduction. The Payroll Benefits Clerk will be able to determine the benefits effective date after all paperwork has been completed and the employee has been set up in the payroll system.

Q. Can benefit elections be changed during the year?
A. An employee cannot change their election during the Plan Year unless the change is the result of one of the qualifying events described below. If the employee does not notify Personnel within 30 calendar days of the qualifying event, notification MUST be considered untimely and the election cannot be changed.

Q. What are considered Qualifying Events?
A. • the marriage, divorce or annulment of the employee
• the death of the employee's spouse or a dependent
• the birth or adoption of a child by the employee
• a change in employment status of the employee or the spouse (i.e., termination or commencement of employment, changes from full-time to part-time, taking an unpaid leave of absence).
• the cost of insurance coverage changes, health insurance coverage changes or ceases during the Plan Year

Q. What happens to my benefits if I am on an unpaid leave of absence?
A. 1) If you are on Family and Medical leave, the Board will continue to pay its portion of the health insurance for up to 12 weeks. You will be required to pay your portion.
2) Other unpaid leave requires that you pay the entire portion of the premium for the duration of your leave.
3) You are responsible for the entire premium for all other benefits (life, dental, vision, cancer, etc.).

Failure to pay for any insurance benefit will result in the termination of your benefits. You are responsible for contacting the Finance Department to make arrangements to pay your premium while you are on a leave of absence. You are also responsible for notifying Finance and Personnel that you have returned from a leave of absence. Failure to notify Finance and Personnel of your return may result in the continued deactivation of your payroll deductions.
ALWAYS REVIEW YOUR PAY STUB TO ASSURE YOUR DEDUCTIONS ARE BEING MADE AND BEING MADE CORRECTLY, ESPECIALLY IF THERE HAS BEEN ANY TYPE OF CHANGE OR IF YOU ARE RETURNING FROM A LEAVE OF ABSENCE.

There is no refund of pre-paid premiums upon the termination of coverage from the GCSB FlexPlan.

The employee is required to present documentation for any status change to Personnel. Untimely submission will result in denial of any request to change payroll deductions.

Q. Other than the situations described above, when may benefit elections be changed?
A. All employees have an opportunity to change their elections during the open enrollment period which occurs once each year during the month of August for an October 1 effective date.

Q. How can benefits terminate?
A. Benefits under the Plan that are described in this booklet can terminate if:
   - employment terminates
   - the policy terminates
   - the provider goes out of business
   - the appropriate contribution is not made for any reason (i.e., on leave**)
   - GCSB amends or terminates the Plan.

**It is the responsibility of the employee to make any payments for benefits when on a leave of absence. Failure to do so will result in termination of coverage.

Q. Who qualifies as a dependent?
A. 1) An employee’s natural child, stepchild, or legally adopted child under the age of 26 years, living in your household, and for whom you are providing a degree of support which allows you to claim him/her on your income tax return (remember one must meet IRS tests to qualify as a dependent).

2) A full or part-time student (at least six hours) under the age of 26 years. Documentation of student status is required by the health plan every year a student is covered. Failure to present this documentation will result in the dependent being dropped from the health plan.

3) Employee’s legal spouse.

4) A child for whom the employee has established legal guardianship. Eligibility for a dependent child usually ceases at the end of the month the child turns 19. Overage dependent children and disabled children may be covered beyond the age of 19. If your child no longer qualifies as a dependent, it is your responsibility to notify Personnel within 30 calendar days. Failure to do so could result in your paying a higher premium for the remainder of the year.
Q. What impact does tax-free benefits have on my Social Security and Florida Retirement System (FRS)?

A. Over the long term, paying less Social Security could slightly reduce your Social Security retirement or disability benefits. However, the impact is very minimal and the taxes you save over the years more than offset the slight reduction you might see at retirement. Your benefits from the FRS are not affected in any way by your participation in the FlexPlan because these benefits are calculated on gross salary.

The Flexible Benefits offered through Gadsden County Schools are outlined on the following pages. If you have additional questions, refer to your summary of benefits or call Personnel.

Note: Important information is distributed through the U.S. mail, both from the School Board and from the providers. It is the responsibility of the employee to keep their personal information current with the Personnel Department and with the providers of the benefits.
GADSDEN COUNTY SCHOOLS BENEFITS CARRIERS

The information provided on the following pages will give a brief overview of Benefits offered to Gadsden County School Board employees. **This is only a summary of current benefits.** If you have specific questions or have a need for more complete details, contact the Insurance Department at 627-9651 ext. 1227, or call:

<table>
<thead>
<tr>
<th>CARRIER</th>
<th>GROUP NUMBER</th>
<th>CONTACT NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Health Plan</td>
<td>00072</td>
<td>850-383-3311</td>
</tr>
<tr>
<td>Blue Cross and Blue Shield of Florida</td>
<td>9107001</td>
<td>800-352-2583</td>
</tr>
<tr>
<td>Florida Combined Life (Dental)</td>
<td>0013875 (Low Option)</td>
<td>877-203-9921</td>
</tr>
<tr>
<td>Florida Combined Life (Life Ins.)</td>
<td></td>
<td>800-333-3256</td>
</tr>
<tr>
<td>AFLAC</td>
<td>60476</td>
<td>800-992-3522</td>
</tr>
<tr>
<td>Unum</td>
<td>0066943 001 7</td>
<td>877-275-3539 800-688-7479 (Claims)</td>
</tr>
</tbody>
</table>
## CAPITAL HEALTH PLAN SCHEDULE OF CO-PAYMENTS

### Physician Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Unit</th>
<th>Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit(s) for services provided by member's primary care physician or other CHP personnel during regular office hours</td>
<td>Per Visit</td>
<td>$15</td>
</tr>
<tr>
<td>Urgent Care service provided by CHP Urgent Care Center or by primary care physician after regular office hours</td>
<td>Per Visit</td>
<td>$25</td>
</tr>
<tr>
<td>Office visit(s) for services provided by a participating provider when authorized by the primary care physician</td>
<td>Per Visit</td>
<td>$40</td>
</tr>
<tr>
<td>Outpatient surgical procedures, surgical services, and other medical care provided by a participating provider when authorized by the primary care physician</td>
<td>Per procedure</td>
<td>$40</td>
</tr>
<tr>
<td>Well-woman visit with network ob/gyn specialist</td>
<td>Per Visit</td>
<td>$40</td>
</tr>
<tr>
<td>Behavioral health outpatient care for short-term evaluative or crisis intervention for 20 visits per calendar year when authorized by primary care physician</td>
<td>Per Visit</td>
<td>$40</td>
</tr>
</tbody>
</table>

### Hospital Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Unit</th>
<th>Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>All hospital benefits covered under this agreement</td>
<td>Per admission</td>
<td>$250</td>
</tr>
<tr>
<td>Outpatient surgical procedures performed in a hospital</td>
<td>Per visit</td>
<td>$250</td>
</tr>
<tr>
<td>Mental health inpatient care</td>
<td>Per admission</td>
<td>$250</td>
</tr>
</tbody>
</table>

### Maternity Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>UNIT</th>
<th>Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visit(s) for services provided by a member's primary care physician</td>
<td>Per visit</td>
<td>$15</td>
</tr>
<tr>
<td>Office visit(s) for services provided by a participating provider when authorized by the primary care physician or non-plan provider when authorized by the Medical Director of CHP</td>
<td>Per visit</td>
<td>$40</td>
</tr>
<tr>
<td>Hospital Services: All maternity inpatient care</td>
<td>Per admission</td>
<td>$250</td>
</tr>
</tbody>
</table>

### Emergency Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Unit</th>
<th>Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room visits</td>
<td>Per visit</td>
<td>$250</td>
</tr>
<tr>
<td>Medically necessary ambulance service</td>
<td>Per occurrence</td>
<td>$100</td>
</tr>
<tr>
<td>Other Benefits</td>
<td>Unit</td>
<td>Co-payment</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Home health services</td>
<td>Per occurrence</td>
<td>$0</td>
</tr>
<tr>
<td>Hospice home care</td>
<td>Per occurrence</td>
<td>$0</td>
</tr>
<tr>
<td>Hospice outpatient care</td>
<td>Per occurrence</td>
<td>$0</td>
</tr>
<tr>
<td>Hospice inpatient care</td>
<td>Per occurrence</td>
<td>$0</td>
</tr>
<tr>
<td>Skilled nursing facility for up to 60 days per admission with</td>
<td>Per confinement</td>
<td>$0</td>
</tr>
<tr>
<td>subsequent admission available following 180 days from discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>date of the previous admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgical procedures performed in an ambulatory surgical</td>
<td>Per visit</td>
<td>$100</td>
</tr>
<tr>
<td>center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment and prosthetic medical appliances</td>
<td>$2,500 maximum benefit per calendar year</td>
<td></td>
</tr>
<tr>
<td>Orthotic and Prosthetic medical appliances</td>
<td>Per appliance</td>
<td>$0</td>
</tr>
<tr>
<td>Diagnostic MRI, PET and CT Scans</td>
<td>Per Scan</td>
<td>$100</td>
</tr>
<tr>
<td>Visits for short-term physical/speech or other rehabilitation</td>
<td>Per visit</td>
<td>$40</td>
</tr>
<tr>
<td>therapies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine eye exams for vision correction</td>
<td>Per visit</td>
<td>$15</td>
</tr>
<tr>
<td>Outpatient prescription drugs</td>
<td>$15/$30/$50</td>
<td></td>
</tr>
</tbody>
</table>

**Exclusions – Co-payments not applicable**

- The maximum amount of co-payment required from any member in any contract year is limited to an amount equal to twice the annual Prepayment Fee applicable to each member or contract.

- The maximum amount of co-payment required for any calendar year is limited to $2000 per member and $4500 per family, excluding co-payments for prescription drugs.

- It is the member’s responsibility to retain receipts and to notify and document, to the satisfaction of CHP, that the co-payment limit has been reached. After that notification and documentation, services will be provided with no co-payment charge for the remainder of the contract year.
CHP Pharmacy Program

CO-PAYMENTS: $15 GENERIC; $30 PREFERRED BRAND; $50 NAME BRAND, NOT ON PREFERRED LIST

The CHP Pharmacy Program provides benefits for Covered Prescription Drugs and Supplies. Each Covered Prescription Drug, when purchased from a Participating Pharmacy, will be subject to a Co-payment amount. The Co-payment amount is determined by the type of Prescription Drug dispensed (i.e., Generic Drug, Preferred Brand Name Drug, or any Brand Prescription Drug not on the Preferred Medication List).

Covered Prescription Drugs must be medically necessary, prescribed by a medical professional acting within the scope of his or her license, dispensed by a Pharmacist,

Drugs Purchased From a Non-Participating Pharmacy

When Covered Prescription Drugs are purchased from a Non-Participating Pharmacy (because of an Emergency Medical Condition, or when authorized by CHP), the Member will be required to pay the full cost of the Drug at the point of service. In order to obtain reimbursement, the Member is required to submit an itemized paid receipt to CHP within 90 days for each Covered Prescription Drug purchased from a Non-Participating Pharmacy.

The itemized paid receipt is required to be submitted to CHP Member Services, P.O. Box 15349, Tallahassee, FL 32317-5349

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Member Handbook/Certificate of Coverage, other than as specifically stated in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Member Handbook/Certificate of Coverage, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Capital Health Plan as expressed herein.

In accordance with the terms of this Endorsement, certain medications need to be approved by CHP before they can be covered for payment. If the Physician prescribes any of the medications on the following list, the person covered by this Endorsement will need to call the Member Services number on the identification card to obtain prior authorization. The Member Services Representative will process the request and the person covered by this Endorsement will be notified if the medication is approved for coverage.

Ultimately, the final decision whether the Prescription Drug should be prescribed must be made by the Member and the prescribing Physician. Decisions made by CHP in administering the Prescription Drug Coverage Prior Authorization Program are made only to determine whether coverage or benefits are available under the Group Plan.
# DEDUCTIBLES

<table>
<thead>
<tr>
<th>Deductibles</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Calendar Year</td>
<td>$2000</td>
</tr>
<tr>
<td>Family Calendar Year</td>
<td>$6000</td>
</tr>
<tr>
<td>Hospital Per Admission - Inpatient</td>
<td>$100+DED+20%</td>
</tr>
<tr>
<td>Emergency Room (All Hospitals)</td>
<td>$300 per visit</td>
</tr>
</tbody>
</table>

NOTE: The calendar year deductible is waived for Independent Clinical Laboratory services. The Hospital Per Admission Deductible and the Emergency Room Per Visit Deductible are in addition to the Calendar Year Deductible.

# PHYSICIAN OFFICE SERVICES

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO Family Physicians (Family Practice, General Practice, Internal Medicine, or Pediatrics)</td>
<td>$35 co-payment</td>
</tr>
<tr>
<td>Specialist</td>
<td>$65 co-payment</td>
</tr>
<tr>
<td>Allergy Injections (PP) Family Physicians</td>
<td>$10 co-payment</td>
</tr>
<tr>
<td>Other PPO Providers and all Non-PPO Providers</td>
<td>Calendar year deductible and coinsurance</td>
</tr>
</tbody>
</table>

Note: Durable Medical Equipment, Prosthetics, and Orthotics are not subject to the Co-payment requirement, but are subject to the Individual Calendar Year Deductible and Coinsurance responsibility.

# CALENDAR YEAR MAXIMUMS PER INSURED

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Services:</td>
<td>0</td>
</tr>
<tr>
<td>- Inpatient days/visits or combination of inpatient and Partial Hospitalization days</td>
<td>0</td>
</tr>
<tr>
<td>- Outpatient visits</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>DED + 20% (20 Visits) In Network</td>
</tr>
<tr>
<td>Skilled Nursing Facility Days</td>
<td>60</td>
</tr>
<tr>
<td>Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations</td>
<td>35 Visits (Includes up to 26 Spinal Manipulations)</td>
</tr>
</tbody>
</table>
**LIFETIME MAXIMUMS PER INSURED**

<table>
<thead>
<tr>
<th>Service</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$5,000,000</td>
</tr>
<tr>
<td>Substance Dependency Care and Treatment</td>
<td>0</td>
</tr>
<tr>
<td>(inpatient, outpatient, or any combination)</td>
<td></td>
</tr>
<tr>
<td>Hospice Benefit</td>
<td>No Maximum</td>
</tr>
</tbody>
</table>
CHOOSING A HEALTH PLAN

A number of factors should be considered before selecting a health plan. One plan is not necessarily “better” than another. Each plan has different characteristics that should be taken into consideration to determine which plan meets an individual’s need. Review the material provided in this publication to help you determine which plan best meets your needs. You may change from one carrier to the other at open enrollment. This is the time to consider any changes to your health care coverages.

Capital Health Plan is a Health Maintenance Organization (HMO). HMO’s are available only to those employees who live or work in the HMO service area. The enrollee must use an exclusive network of providers to obtain services and generally, there is no option to use non-network physicians or providers.

Blue Cross and Blue Shield of Florida is a Preferred Provider Organization (PPO). Blue Cross and Blue Shield of Florida uses a statewide network of physicians and providers, but has arranged for out-of-state coverage through the Blue Cross and Blue Shield of Florida BlueCard Program. The enrollee may use out-of-network providers as long as the enrollee is willing to pay the additional costs incurred when services are received from non-network providers. Questions regarding the BlueCard Program should be directed to Blue Cross and Blue Shield of Florida Customer Services Representatives at 1-800-825-BLUE (2583). Enrollees may also visit the web site at www.bluecares.com.

Note: The Board Contributions and Employee Costs are based on negotiated contracts and School Board Policy and are subject to change. Any changes in information will be provided as soon as it is available.

<table>
<thead>
<tr>
<th>Types of Coverage</th>
<th>Capital Health Plan Employee Contribution</th>
<th>Capital Health Plan Board Contribution</th>
<th>Blue Cross Blue Shield Employee Contribution</th>
<th>Blue Cross Blue Shield Board Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>118.64</td>
<td>333.01</td>
<td>150.93</td>
<td>368.47</td>
</tr>
<tr>
<td>Employee &amp; Spouse</td>
<td>525.14</td>
<td>333.01</td>
<td>618.41</td>
<td>368.47</td>
</tr>
<tr>
<td>Employee &amp; Child</td>
<td>434.82</td>
<td>333.01</td>
<td>514.54</td>
<td>368.47</td>
</tr>
<tr>
<td>Family</td>
<td>931.64</td>
<td>333.01</td>
<td>1085.88</td>
<td>368.47</td>
</tr>
</tbody>
</table>

All deductions are made on a twelve-deduction basis (July -June)

For continuing current employees, enrollment in the Healthcare Program occurs once each year in August for an October effective date.
NOTE: Capital Health Plan suggests you notify Personnel and pre-enroll your baby prior to the child's expected date of birth, but you are required to do so within 30 days of the birth. Failure to meet these time lines will result in the newborn not having healthcare coverage.

BlueCross and BlueShield of Florida – You must notify the company within 30 calendar days of the newborn’s date of birth. Failure to do so will result in the newborn not having healthcare coverage.

Any other family status change must be reported to Personnel within thirty 30 calendar days of occurrence, and appropriate paperwork must be completed. Your GCPS Benefits FlexPlan WILL NOT be changed if there is no notification or if notification of family status change is untimely.

Employees returning from a leave of absence must notify the Insurance Department within 30 days of their return in order to continue benefit deductions.

MENTAL HEALTH/SUBSTANCE ABUSE

Contact your health care provider in the event you need mental health or substance abuse services. These services are provided by your health care plan.
DENTAL CARE
The Dental Care Program being offered through GCPS is Florida Combined Life Insurance Company, Inc. and its parent company Blue Cross and Blue Shield of Florida, Inc. Below is a summary of the dental benefits. For additional information, you may contact the company directly at www.bcbsfl.com.

<table>
<thead>
<tr>
<th>DEDUCTIBLE (For Basic and Major Services Only)</th>
<th>Participating Dentist</th>
<th>Non-Participating Dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Person Per Plan Year</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Per Family Per Plan Year</td>
<td>$150</td>
<td>$150</td>
</tr>
</tbody>
</table>

Note: In-Network deductible credits apply to Out-of-Network deductible and Out-of-Network deductible credits apply to In-Network.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Company Pays*</th>
<th>You Pay*</th>
<th>Company Pays**</th>
<th>You Pay***</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREVENTIVE (some limitations may apply)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Oral Evaluations (Exams)</td>
<td>100%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>- Bitewing X-rays</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Prophylaxis (Cleanings) - Adult/Child</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Fluoride Treatment - Child</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BASIC (some limitations may apply)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- X-rays - intra oral/Complete Series/Panoramic</td>
<td>80%</td>
<td>20%</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>- Sealants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Amalgam Restorations (Silver Fillings)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Resin-Based Restorations - Anterior &amp; Posterior</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Root Canal Therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Periodontal Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Extractions - Routine and Surgical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAJOR (some limitations may apply)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Crowns - Single Restorations</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>- Osseous Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Complete Dentures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Partial Dentures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Fixed Partial Dentures (Bridges)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Benefit Waiting Period</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>ORTHODONTIA SERVICES</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>PLAN YEAR MAXIMUM BENEFIT PER PERSON</td>
<td>LOW OPTION $1,000</td>
<td>HIGH OPTION $2,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Percentage of fee schedule
**Payment is based on Usual, Customary and Reasonable Charge.
***The majority of dentists’ fees are within allowed charges; however, you will be responsible for any fees in excess of the allowed amount.
The information provided is a summary of benefits for group certificate: 50534-1103. It is intended to highlight key points of the Dental Plan and is provided to the employee as an aid in deciding whether to enroll in the Plan. This summary should in no way be construed as part of the contract. Possession of this summary in no way implies coverage nor does it guarantee benefits under the plan.

<table>
<thead>
<tr>
<th></th>
<th>Low Option Board Cont.</th>
<th>Low Option Employee Cont.</th>
<th>High Option Board Cont.</th>
<th>High Option Employee Cont.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$17.69</td>
<td>0</td>
<td>$17.69</td>
<td>$7.75</td>
</tr>
<tr>
<td>Employee &amp; Spouse</td>
<td>$17.69</td>
<td>$26.39</td>
<td>$17.69</td>
<td>$35.64</td>
</tr>
<tr>
<td>Employee &amp; Children</td>
<td>$17.69</td>
<td>$25.86</td>
<td>$17.69</td>
<td>$35.09</td>
</tr>
<tr>
<td>Employee &amp; Family</td>
<td>$17.69</td>
<td>$58.25</td>
<td>$17.69</td>
<td>$68.95</td>
</tr>
</tbody>
</table>

**LOCAL AREA PROVIDER LIST**

**CALHOUN**
**BLOUNSTOWN**
**General Dentist**
Cobb, Glenwood B
Layne, Raymond H, Jr.

**GADSDEN**
**CHATTAHOOCHEE**
**General Dentist**
Melzer, James F.

**QUINCY**
**General Dentist**
Pandit, Himanshu

**LEON**
**TALLAHASSEE**
**General Dentist**
Alniti, Daniel
Alon Alon, Maryrose
**Aspros, Steven**

**Endodontist**
Ruiz Hubbard, ED

**Pedodontist**
Butler, Mary A
McLarty, E L
Sheppard, Stanley A

**Aspros, Steven**

You can choose a Provider not listed, willing that Provider’s office will file the claim with Florida Combined Life.
Please feel free to visit the website at [www.bcbsfl.com](http://www.bcbsfl.com) for the most up to date provider information.

**Provider is not accepting new patients at this time**
GROUP TERM LIFE ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

The Board provides life insurance equal to one year’s salary for each employee at no charge. Florida Combined Life is the provider of this Basic Group Coverage. The Board also provides Accidental Death and Dismemberment Insurance for You.

Life Insurance

1. If you have not reached age 65, your amount of insurance will be 100% of your annual pay, subject to a minimum amount of insurance of $10,000, and to a maximum amount of insurance of $100,000.*

Annual pay means your basic yearly pay from the policyholder or an associated company, and is computed on a yearly basis. Bonuses, overtime, and other compensation not considered by Assurant as basic wages or salary are not included.

2. If you have reached age 65, but not age 66, your amount of insurance will be 90% of the amount shown in 1 above.*

3. If you have reached age 66, but not 67, your amount of insurance will be 80% of the amount shown in 1 above.*

4. If you have reached age 67, but not 68, your amount of insurance will be 70% of the amount shown in 1 above.*

5. If you have reached age 68, but not 69, your amount of insurance will be 60% of the amount shown in 1 above.*

6. If you have reached age 69 or more, your amount of insurance will be 50% of the amount shown in 1 above.*

* Your amount of insurance will be rounded to the next highest multiple of $1,000, if not already an exact multiple. Any reduction will be subject to the other provisions of the policy and will also apply if your insurance is continued during disability.

However, the amount of life insurance may be limited by the Proof of Good Health provision.

If any or all of your group life insurance ends, you can apply for any individual policy (conversion policy). **You must apply and pay the premium within 31 days.** The individual policy may be any they customarily issue, except term insurance. No proof of good health is required. The amount of insurance available to you depends on the reason your insurance ends.

If your insurance ends because you are no longer eligible or because of a change in age or other status, you may convert the full amount that ended. However, if your insurance ends as the result of a change in the policy, your may not convert the full amount that ended.
If the policy ends or is changed to reduce or end your life insurance, and if you have been insured for at least 5 years under the policy, you may convert up to the lesser of

- $10,000.
- the amount of life insurance that ended minus the amount of any group life insurance for which you become eligible within 31 days.

If you die within 31 days after your life insurance ends, we will pay to your beneficiary the amount you could have converted, whether or not you applied or paid the premium.

You cannot apply for a conversion policy if your group life insurance ended because you did not pay your share of the premium.

**Accidental Death Insurance**

If you die as the direct result of an injury, we will pay your beneficiary the amount of Accidental Death and Dismemberment Insurance shown in the Schedule. The insurance will be paid only if death occurs within 365 days after the injury. This 365 day limit will not apply if you are in a coma or being kept alive by an artificial life support system at the end of the 365 days.

**Accidental Dismemberment Insurance**

If you suffer one or more of the following losses as the direct result of an injury, we will pay the benefit shown:

<table>
<thead>
<tr>
<th>Covered Loss</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 hand, 1 foot, or the sight of 1 eye</td>
<td>½ the amount of Accidental Death and Dismemberment Insurance</td>
</tr>
<tr>
<td>Any 2 or more of the above</td>
<td>The full amount of Accidental Death and Dismemberment Insurance</td>
</tr>
</tbody>
</table>

Loss of a hand or foot means permanent severance at or above the wrist or ankle. Loss of sight of the eye means total and permanent loss of sight. The loss must occur within 365 days after the injury.

You cannot convert your accidental death and dismemberment insurance to an individual policy.

**Voluntary Life Insurance**

Employees may purchase additional term life insurance for themselves and for immediate family members. This year all employees, who have not yet reached 70 years of age, may choose an amount of insurance equal to $10,000, $25,000, $50,000, $75,000, or $100,000 without evidence of insurability. If you have reached age 70 or more, the amount of insurance and premiums charged will be reduced by 50%.
<table>
<thead>
<tr>
<th>AGE</th>
<th>RATE</th>
<th>AGE</th>
<th>RATE</th>
<th>AGE</th>
<th>RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19</td>
<td>.03/1000</td>
<td>35-39</td>
<td>.08/1000</td>
<td>55-59</td>
<td>.66/1000</td>
</tr>
<tr>
<td>20-24</td>
<td>.04/1000</td>
<td>40-44</td>
<td>.14/1000</td>
<td>60-64</td>
<td>.89/1000</td>
</tr>
<tr>
<td>25-29</td>
<td>.05/1000</td>
<td>45-49</td>
<td>.19/1000</td>
<td>65-69</td>
<td>1.40/1000</td>
</tr>
<tr>
<td>30-34</td>
<td>.05/1000</td>
<td>50-54</td>
<td>.35/1000</td>
<td>70-74</td>
<td>1.95/1000</td>
</tr>
</tbody>
</table>

Spouses may be approved for $10,000 including AD&D ($3.98) and dependent children (14 days old but less than age 19 or less than age 25 if a full-time student) may be approved for $5,000 including AD&D ($0.71) providing the employee also chooses additional coverage.

An employee may choose to change the amount of insurance, from August 1 through August 31 of each year, the annual enrollment period but YOU MUST SUBMIT PROOF OF GOOD HEALTH FOR ANY SUCH INCREASE.

**MEDICAL REIMBURSEMENT ACCOUNTS**

By participating in a Medical Expense Reimbursement Account, you can reimburse yourself tax free for many of those medical expenses not covered by insurance. These funds are set aside from your salary before taxes are deducted.

**Eligible Expenses (Partial List)**

- Acupuncture
- Ambulance service
- Birth control pills and devices
- Chiropractic care
- Contact lenses (corrective)
- Dental fees
- Diagnostic tests/health screening
- Doctor fees
- Drug addiction/alcoholism treatment
- Eyeglasses
- Guide dogs
- Hearing aids and exams
- In vitro fertilization
- Injections and vaccinations
- Nursing services
- Optometrist fees
- Orthodontic treatment
- Over-the-counter items
- Prescription drugs to alleviate nicotine withdrawal symptoms
- Smoking cessation programs/treatments
- Surgery
- Transportation for medical care
- Wheelchairs
- X-rays
These are examples and not all inclusive.

**Ineligible Expenses**

- Insurance premiums
- Vision warranties and service contracts
- Cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition

Once you sign up for a Medical Expense FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage.

Since you don’t have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses at the start of your deductions.
OPTIONAL BENEFITS

CANCER

- First Occurrence
- Hospital Confinement
- Cancer Screening Wellness
- Medical Imaging
- Immunotherapy
- Radiation & Chemotherapy
- Plus ... much more

What makes a current Aflac Cancer policy different?

- Provides a cash benefit for just about every part of the treatment regimen, from hospital confinement to radiation and chemotherapy.
- Pays a first-occurrence benefit when a covered individual is first diagnosed as having internal cancer.
- Pays you directly, unless you tell them otherwise, no matter what other insurance you may have.

HOSPITAL INTENSIVE CARE

- Daily Hospital Intensive Care Unit
- Daily Sub-Acute Intensive Care Unit
- Major Human Organ Transplant
- Progressive Benefit

What makes a current Aflac Hospital Intensive Care policy different?

- Pays you directly, unless you tell them otherwise, no matter what other insurance you may have.
- Pays cash benefits fast—usually within four days of receiving the claim.
- Backs policies with over 50 years in the business and an AA- rating in insurer financial strength by Standard and Poor’s.

HOSPITAL INDEMNITY

- Annual Hospitalization Confinement
- Daily Hospital Confinement
- Outpatient Surgery
- Invasive Diagnostic Exams
- Wellness
- Plus ... more

What makes a current Aflac Hospital Confinement Indemnity policy different?

- Pays a benefit when you’re required to stay in a hospital for 23 hours or more for a covered sickness or injury.
- Pays you directly, unless you tell them otherwise. No matter what other insurance you may have.
- Pays cash benefits fast—usually within four days of receiving the claim.

VISION

- Eye Examination
- Vision Correction
- Eye Surgery
- Specific Eye Diseases/Disorders
- Permanent Visual Impairment

- Pays you directly when a charge is incurred for an eye examination.
- Pays a benefit when you are first diagnosed as having specific eye diseases.
- Pays you when a surgical operation is performed for a diagnosed eye disease or disorder.
- Pays cash benefits when a person is first diagnosed with a visual impairment.
CRITICAL CARE & RECOVERY

- Heart Attack
- Stroke
- Coronary Artery Bypass Surgery
- Coma
- End-Stage Renal Failure
- Major Third-Degree Burns
- Major Human Organ Transplant

Optional First-Occurrence Building Benefit Rider

- Pays a First-Occurrence Benefit as well as hospital confinement and continuing care benefits.
- Pays you directly, unless you tell them otherwise, no matter what other insurance you may have.
- Pays cash benefits fast—usually within four days of receiving the claim.

ACCIDENT

- Emergency Treatment
- Follow-up Treatment
- Initial Hospitalization
- Hospital Confinement
- Physical Therapy
- Accidental-Death
- Wellness
- Plus ... much more

What are the advantages of an Aflac Accident insurance policy?

- Pays cash benefits that help you manage the expenses incurred after an accidental injury, such as copayments and treatment-related travel, as well as the ongoing expenses of your ordinary bills such as rent, electricity, and car payments.
- Pays you directly, unless you tell them otherwise, no matter what other insurance you may have.
- Pays cash benefits fast—usually within four days of receiving your claim.
- Accident policies are portable, which means that you can continue your coverage if you change jobs or retire.
- Family coverage is available.
- Unless you choose to upgrade your policy upon renewal, your rates don’t go up, even if you file a claim.

DISABILITY INCOME PROTECTION

- Selection of Monthly benefit amount, elimination period, benefit period
- Benefits paid regardless of any other insurance
- Guaranteed renewable to age 70

How can Aflac’s Short-Term Disability policy help you?

- Your policy stays with you even if you switch jobs.
- Pays a cash benefit for each day you’re disabled.
- Pays you directly, unless you tell them otherwise, no matter what other insurance you may have.

Note: Employees who are going on approved leave must contact Aflac to continue their FlexPlan. If you retire or leave the employment of the Gadsden County School System, you may continue your Aflac policies at the same rate.

Want to learn more? Call 531-9908 in Tallahassee or 1-800-99-AFLAC (1-800-992-3522) today.
UNUM (Not Pre-taxed)

Short Term Disability Income Protection Insurance Plan Highlights

**Eligibility**: You are eligible for coverage if you are an active employee working a minimum of 20 hours per week.

**Guarantee Issue**: You may apply for coverage without answering any medical questions or providing evidence of insurability if you apply for coverage within 31 days after your eligibility date for a **new hired employee**. If you apply more than 31 days after your eligibility date, your coverage will be medically underwritten, and you will be required to qualify based on information you provide on your overall medical health including routine, planned, unplanned or ongoing medical care or consultation. This review may result in a declination of coverage.

**Weekly Benefit**
If you meet the definition of disability, you would be eligible to receive a weekly benefit equal to 60% of your weekly earnings, to a maximum of $1,200 per week.

**Definition of Disability**
- You are disabled when Unum determines that:
  - you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
  - you have a 20% or more loss in weekly earnings due to sickness or injury.

**Elimination Period**
The elimination Period is the length of time of continuous disability which must be satisfied before you are eligible to receive benefits.

- Enhanced Disability Option I - 14 Day Elimination Period
- Enhanced Disability Option 2 - 60 Day Elimination Period

**Benefit Duration**
If you meet the definition of disability, you may receive a benefit for up to 24 weeks for Option 1 and for up to 18 weeks for Option 2.

Long Term Disability Income Protection Insurance Plan Highlights

**Eligibility**
You are eligible for LTD coverage if you are an active employee working a minimum of 20 hours per week.

**Weekly Benefit**
If you meet the definition of disability, you would be eligible to receive a weekly benefit equal to 60% of your weekly earnings, to a maximum of $5000 per week.

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings, unless the excess amount is payable as a Cost of Living Adjustment. However, if you are participating in Unum’s Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110%of your monthly earnings (unless the excess amount is payable as a Cost of Living Adjustment).
Your disability benefit may be reduced by deductible sources of income and any earnings you have while disabled. Deductible sources of income may include such items as disability income or other amounts you receive or are entitled to receive under: workers’ compensation or similar occupational benefit laws; state compulsory benefit laws; automobile liability and no fault insurance; legal judgments and settlements; certain retirement plans; salary continuation or sick leave plans; other group or association disability programs or insurance; and amounts you or your family receive or are entitled to receive from Social Security or similar governmental programs.

**Definition of Disability**

You are disabled when Unum determines that:

- you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and

- you have a 20% or more loss in weekly earnings due to the same sickness or injury.

You will continue to receive benefits if:

- after benefits have been paid for 24 months, you are working in any occupation and continue to have a 20% or more loss in indexed monthly earnings due to your sickness or injury; or

- you are not working and, due to the same sickness or injury, are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

**Elimination Period**

The Elimination Period is the length of time of continuous disability which must be satisfied before you are eligible to receive benefits. During your elimination period you will be considered disabled if you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury, and you are under the regular care of a physician. You are not required to have a 20% or more earnings loss to be considered disabled during the elimination period due to the same sickness or injury.

**Benefit Duration**

Your duration of benefits is based on when the disability occurs. Your LTD benefits are payable for the period during which you continue to meet the definition of disability. If your disability occurs before age 60, benefits will be payable until age 65. If your disability occurs at or after age 60, benefits would be paid according to a benefit duration schedule.
Gainful Occupation

Gainful occupation means an occupation that is or can be expected to provide you with an income at least equal to your gross disability payment within 12 months of your return to work:

.80% of your indexed monthly earnings, if you are working.

.60% of your indexed monthly earnings, if you are not working.

Waiver of Premium

You will not be required to pay LTD premiums as long as you are receiving LTD benefits.

<table>
<thead>
<tr>
<th>Age</th>
<th>Short Term Disability Rates</th>
<th>Long Term Disability Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Starting at either 14 days or 60 days</td>
<td>Starting at either 90 days or 180 days</td>
</tr>
<tr>
<td></td>
<td>Per $100 of Covered Monthly Salary</td>
<td>Per $100 of Covered Monthly Salary</td>
</tr>
<tr>
<td>&lt;25 years</td>
<td>$0.88</td>
<td>$0.18</td>
</tr>
<tr>
<td>25 - 29</td>
<td>$0.97</td>
<td>$0.26</td>
</tr>
<tr>
<td>30 - 34</td>
<td>$0.86</td>
<td>$0.40</td>
</tr>
<tr>
<td>35 - 39</td>
<td>$0.72</td>
<td>$0.56</td>
</tr>
<tr>
<td>40 - 44</td>
<td>$0.72</td>
<td>$0.72</td>
</tr>
<tr>
<td>45 - 49</td>
<td>$0.78</td>
<td>$1.00</td>
</tr>
<tr>
<td>50 - 54</td>
<td>$0.90</td>
<td>$1.35</td>
</tr>
<tr>
<td>55 - 59</td>
<td>$1.23</td>
<td>$1.65</td>
</tr>
<tr>
<td>60 - 64</td>
<td>$1.57</td>
<td>$1.65</td>
</tr>
<tr>
<td>65 - 69</td>
<td>$1.78</td>
<td>$2.03</td>
</tr>
<tr>
<td>70 +</td>
<td>$1.78</td>
<td>$2.64</td>
</tr>
</tbody>
</table>

To apply for coverage, complete an enrollment form within 31 days of your eligibility date. After that date you will be required to provide evidence of insurability in order to qualify for coverage. This will include a review of your overall medical health including routine, planned, unplanned or ongoing medical care or consultation, and may result in a declination of coverage.
TAX-SHELTERED ACCOUNTS (403B)

To help you plan toward your retirement and boost your income at that time in your life, tax deferred accounts are available. The companies that have been approved to offer these products through payroll deduction are:

<table>
<thead>
<tr>
<th>Corporate</th>
<th>Corporate</th>
<th>Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>AXA Equitable Life Insurance Co.</td>
<td>1-800-628-6673</td>
<td>James Frank</td>
</tr>
<tr>
<td></td>
<td></td>
<td>893-9535</td>
</tr>
<tr>
<td>ING Retirement</td>
<td>1-800-584-6001</td>
<td>Karen Wells</td>
</tr>
<tr>
<td></td>
<td></td>
<td>875-3579</td>
</tr>
<tr>
<td>Life Insurance Co. of the Southwest</td>
<td>1-800-579-2878</td>
<td>Ether Lee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(954)796-1137</td>
</tr>
<tr>
<td>Lincoln Financial Group</td>
<td>1-800-454-6265</td>
<td>Bob Butler</td>
</tr>
<tr>
<td></td>
<td></td>
<td>224-8052</td>
</tr>
<tr>
<td>Mass Mutual</td>
<td>1-800-228-2479</td>
<td>Bob Butler</td>
</tr>
<tr>
<td></td>
<td></td>
<td>224-8052</td>
</tr>
</tbody>
</table>

You should compare these companies, their products, their services, and the return on investments and make a decision that best suits your needs. Participation may begin at anytime. However, School Board Policy requires a minimum participation of 25 employees for a company to be granted a payroll deduction slot. Take this into consideration as you make a decision on participation.